



Specialty Pharmacy Medical Request

Allied Benefit Systems
PO Box 909786-60690
Chicago, IL 60690-9786

P Please refer to the phone number listed on the back of the member's ID card.
F 312-281-1636
E SpecialtyRx@alliedbenefit.com

All relevant information must be completed. Allied's receipt of this completed form does not constitute a guarantee of benefits.

When submitting a prior authorization request, please note the following information is necessary when applying criteria and determining medical necessity:

Copy of the Rx Order or Script. *(Required)*

Letter of Medical Necessity. *(Required)*

3-6 months of clinical information including medical history, physical exams and most current progress notes. *(Required)*

Current medications as well as medications that have been TRIED/FAILED. *(Required)*

Any **pertinent** lab work, including fecal occult blood test, culture reports, Hematocrit, Hemoglobin, Hormone studies and TSHs.

Any **pertinent** imaging reports, such as U/S, X-rays, CTs.

Today's Date:			Date Medication Needed:			
Duration of Authorization:		1 Month	3 Months	6 Months	12 Months	Other
Request:						
Initial		Continuation of Care		Appeal		
SECTION A - PATIENT INFORMATION						
Patient's First Name			Patient's Last Name			
Employee's First Name			Employee's Last Name			
Employee's SS#						
Address			City	State	Zip	
Home Phone		Work Phone		Cell Phone		
DOB	Height	Weight	Allergies			
SECTION B - INSURANCE INFORMATION						
Primary Insurance			Pharmacy Benefit Manager			
ID #	Group #		Insured	Phone		
Medicare?	If yes, provide #		Medicaid?	If yes, provide #		
Yes	No		Yes	No		
Secondary Insurance			Pharmacy Benefit Manager			
Policy #	Group #		Insured	Phone		

SECTION C - PHYSICIAN INFORMATION

First Name				Last Name			
Address				City		State	Zip
Phone	Fax	St Lic. #	NPI #		DEA #	UPIN	
Office Contact Name				Phone			

SECTION D - CURRENT MEDICAL INFORMATION ONLY

Primary Diagnosis	ICD-10 Code		Secondary Diagnosis	ICD-10 Code	
Requested Medication Name	Dose/Strength	Frequency	Directions	Quantity	# of Refills
HCPCS/CPT Code	Dose/Strength	Frequency	Directions	Quantity	# of Refills
Tried and Failed Medications pertaining to request above.	Dose/Strength	Frequency	Directions	Quantity	# of Refills

SECTION E - BILLING AND SHIPPING INFORMATION

Is this Provider going to supply and bill for the medication?	Yes	No
If YES , is the Physician listed in section C the one billing for this medication?	Yes	No
If NO , please provide the name and phone number for the Physician or Facility supplying and billing for this medication.		

Name:	Phone Number:
Authorization Number (if required)	

Administration Site:			
Physician's Office	Patient's Home	Home Care Agency	Ambulatory Infusion Center
Patient Administered Oral		Patient Administered Injectable	

All required sections must be completed in full to ensure covered prescriptions ship within 3-7 business days. If these sections are not completed accurately, your order may be delayed.

Shipping: (If shipping is required, please complete below.)

Physician's Office	Home Care Agency (name and address if available)
Patient's Home	Ambulatory Infusion Center (location address)

Prescriber's Signature (required by law)	Date
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